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Allegheny County Medical Society

Bulletin

MAY 2016 / VOL. 106 NO. 5

Articles

Feature .............................. 187
In memoriam: Peter J. Jannetta, MD 1932-2016
Jack Wilberger, MD

Materia Medica ..................... 200
Genvoya© (elvitegravir, cobicistat, emtricitabine, tenofovir)
Anna Bondar, PharmD
Ashley Campbell, PharmD, BCPS

Legal Report ....................... 202
Employed physician liability for compliance issues: Contractual, regulatory and governmental traps
Beth Anne Jackson, Esq.

Special Report ..................... 204
What can I do if I did not meet Meaningful Use in 2015?

Special Report ..................... 205
Gateway Medical Society update

Special Report ..................... 206
ACMS Health Careers Endowed Scholarship

Special Report ..................... 207
Regional Health Literacy Coalition forum: Moving Health Literacy Forward
Kevin Progar

Perspectives

Editorial ........................... 178
The gag rule?
Deval (Reshma) Paranjpe, MD, FACS

Editorial ........................... 182
Update from the 2016 NAC
Amelia A. Paré, MD, FACS

Perspective ......................... 186
Root causes: Doing what is necessary
Amy G. Nevin, MD

On the cover

Sunflowers
by Michelle Kirshen, MD
Dr. Kirshen specializes in radiology.

Departments

Activities & Accolades ...... 188

In Memoriam ...................... 190
• Norman Bruce Tannehill, MD
• Peter J. Jannetta, MD
• Narasimman Srinivasagam, MD

Society News ...................... 192
• TAPI meeting, symposium held
• Pittsburgh Regional Science & Engineering Fair
• Pennsylvania Geriatrics Society – Western Division
• Pittsburgh Urology Associates
• National Kidney Foundation
• Greater Pittsburgh Diabetes Club
• Pa. lawmakers legalize medical marijuana

ACMS Alliance News .......... 199

Classifieds ......................... 208

Community Notes .............. 208

2016 Bulletin Photo Contest:
See Page 209.
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Savings, Service and Solutions!
Most of us have had a few patients who make us want to wear a pin to work that says, “Please do not confuse your Google search with my medical degree.” It’s refreshing to have a well-informed patient, but what do you do when you have an ill-informed patient who is convinced that he/she alone is right? That question alone may drive you to distraction, but when that patient happens to be a loved one, it may drive you to despair.

The reason we don’t treat our own families and close friends for serious problems is because our deep emotional involvement may cloud our judgment and lead us to unintentionally overtreat, undertreat, or mistreat. The shoemaker’s children always either go barefoot or wear six-inch stilettos that are two sizes too small. Better to leave the actual treatment to trusted colleagues who can view the situation objectively but still compassionately.

The other reason that we don’t treat loved ones, I am convinced, is because having a physician-patient relationship with your loved one may play havoc with your interpersonal relationship. I think one of the most frustrating things I’ve ever experienced has been listening to a loved one recently diagnosed with a life-altering illness frenetically rattle off a long list of doom-and-gloom Google University statements that he takes as holy writ. The physician in me wants to help him like I would any patient, only more so.

Any attempts to do this though, however gentle, are invariably met with a passionate lecture on how “I’ve researched everything, doctors just don’t care, and the only one looking out for me is myself.” The weight and fear of illness have cast even me, an old friend who wants to help, as the enemy in his eyes because of my medical degree. His coping mechanism is the mantra: “It’s me against the medical establishment,” and because I am part of that establishment, I am the punching bag. Ah, the ironies of life. It hurts me, to be sure, but the hurt that matters here isn’t mine – it’s his. There are burdens to illness beyond the physical, the financial and the psychological – illness affects relationships, too.

I vented my frustrations to a mutual friend, and said: “So basically, I have to pretend that I have no medical knowledge ...” to which this wise mutual friend said, “Exactly. Our job is to listen. Let him know you stand ready to assist, but don’t volunteer help unless he firmly asks for it.”

When your entire raison d’etre as a professional is to provide help, and to volunteer help to people who don’t even know they need it sometimes, this can be one of the hardest things you’ve ever had to do. It certainly has been for me. I’m on the other side of the country and not involved in his care, so I’ll try.

“Fine,” I said. “If I see him about to go off a cliff I will step in, but otherwise, I’ll just listen.”

So I force myself to bite my tongue and just listen to each long torrent of fears and statements and misstatements by text, phone and email, and say things like: “It sounds like you’re angry,” or “I’m hearing that you’re feeling scared,” to let him know that I am registering his emotions and validating them.

But a funny thing happens when you let go of your identity as a physician and just listen as a layman friend. You start to hear things you may never have before, and realize just how much impact simple things can have on the patient-physician relationship. I listen to his complaints about doctors, and while I know exactly how each one of his disaster stories could have taken place from the physician side, I now fully appreciate how much they can impact a patient in ways I’d never fully imagined.

I leave you with some observations that I am making along the way. I wish I could pass them on to his physicians; I am hoping that they will make me a better physician, and I hope that you may find them useful, too.

1. Even young, highly educated, highly intelligent professionals will
Editorial

not hear anything after you say the “C” word. But it’s not just cancer that induces shock. So does the “A” for Autoimmune disease; the “N” for you need to see a Neurosurgeon; the “S” for you need Surgery; the “H” for Hereditary; the “D” for Disability; and the “V” for Vision loss. As an ophthalmologist, I learned years ago that the magic words after giving a patient a diagnosis they’ve never heard of are the blunt: “You are not going to go blind from this.” (The disclaimer that follows is that no one can guarantee this of course, but the statistics would generally back up the statement.) Once those magic words are uttered, the shock dissipates, and you can have a conversation. Don’t underestimate the shock that a young, educated, rational and reasonable person will feel when you give them a diagnosis – any diagnosis. My friend is convinced that he is going to die slowly and painfully from multi-organ failure in the near future when the literature suggests anything but this outcome.

2. Patients young and old all appreciate being given information on a diagnosis and credible, legitimate websites and support groups to research. The biggest complaint my friend had after being given his diagnosis was not only the lack of handholding, but also the lack of information/resources he was given. Imagine being told: “You have cancer; see you later.” The emotional support and information he expected from his physician did not come, so instead he sought it out on Internet support groups, which have scared him silly because they sometimes self-select for patients who have the worst experiences (and don’t get outside support). So, spend some time counseling someone after you give them any diagnosis. Look into Internet resources and Internet or local support groups, and direct your patients toward credible, helpful ones. Tell the patient to call you if they go home and have questions – and mean it.

3. Even when a patient says he’s OK and he understands, he may not really understand. My friend can put up a really grand front because he doesn’t want to appear weak or scared or nervous, and because he’s too scared or stunned to ask some questions. He can say “Everything’s great!” to his doctor, and fall apart completely when talking to his friends. This is why we usually ask a friend or family member to be present when anything momentous is going to be discussed. The loved one serves as an accessory brain, note-taker and question-asker if the patient is too overwhelmed to process or think rationally and ask the necessary questions. But what you might not realize is that the loved one accompanying the patient may be a) useless; b) disinterested; or even c) antagonistic to the patient. I met a well-educated acquaintance recently who didn’t see the point of accompanying her parent to an upcoming surgical visit “because it’s not like I’m going to change her mind if she wants to do something either way.” I had to explain her “duties” as the accompanying relative – listen, advocate, ask questions, take notes. This was a great revelation to her. So, newsflash: There are plenty of clueless people out there.

4. If you don’t know much about a particular disease, educate yourself and get back to the patient – and follow through. Keep an open mind, don’t dismiss symptoms simply because someone is seemingly young and healthy, and follow up. If you don’t know all the side effects of a treatment that you are suggesting, learn them, and at least give the patient some objective information about them so that he doesn’t terrify himself into rejecting a potentially beneficial treatment based on what he heard on an Internet chat board at 2 a.m. one sleepless night.

5. Your front desk staff, receptionists and assistants are your public front. If they are terrible, you are perceived as terrible. There may not be much you can do if you didn’t hire them (or sometimes even if you did), but at least ask your patients if their experience with your front desk is OK. The last person to know and the first person to have a professional reputation blackened by the rudeness and inattentiveness of staff is you. For example, my friend saw a world-class physician at a world-class facility. However, to get an urgent prescription called in to his local pharmacy, it took two hours in a waiting room waiting for a nurse to simply take down a pharmacy number, and then more than 24 hours to get the actual prescription called in to the pharmacy. “I don’t think I’m in good hands here,” said my friend, confidence understandably shaken. You are only as good as your staff. Patients don’t understand that good help may be hard to find; if you can’t change the situation, at least acknowledge it and provide workarounds.

6. Make sure your patients know that you are human. Take a moment if you can, and acknowledge their feelings, their shock, their panic. Hold their hands, literally and figuratively. My friend cannot shake the feeling that every physician he meets is a robot, dispassionately delivering diagnoses and test results, and never considering

Continued on Page 180
the effect of either the news or the diseases on the patient as a human being. Think of what the side effect of deafness might mean to a musician, or how the loss of color and contrast sensitivity might devastate a visual artist before you say: Here, take this medicine. Make it a partnership from the beginning rather than a therapeutic contract, lest it turn into an adversarial relationship. This might take more emotional energy than you have, but summon it, and then go recharge yourself.

7. If you start to get impatient or upset, remember to leave your ego and your own feelings out of it. This is about your patient’s treatment and experience. Resist the temptation to label someone “crazy” or “difficult;” try to figure out what’s making things so difficult for them and see if you can help. Maybe it’s an abusive home life, or a demanding job, or a crippling childhood fear. You may have better luck achieving treatment goals if you delve a little deeper.

8. Young people, and the young at heart, and people who have never really faced illness in their lives are devastated by the prospect of loss of function, loss of the future they had wished, and, most of all, loss of possibilities. When you tell someone they have a chronic disease, they may hear instead: “You’ll never have a relationship, or children, or anyone to take care of you when you get old. No one will want to date you, let alone marry you and take on the burden of your illness. You’re going to die sick and alone.” It’s important that you reinforce that they can, with treatment, live a pretty normal life if that is indeed the case. Ask: “What frightens you? Tell me, so we can work through this together.”

9. Be careful that the questions you ask don’t appear to make judgments. If someone’s single or divorced or gay or all three when the majority of their peer group is married, that’s still none of your business unless it relates to their medical care. If you have to ask these questions, make sure your patient knows why. Perhaps ask: “Who in your life do you lean on for support, whether physical or emotional?” The chaplains have it right; one of their questions is: “Primary source of hope?”

10. Lastly, remember to take care of yourself. All of this takes an enormous amount of emotional energy on your part. If you don’t recharge your own batteries, you’ll have nothing to give emotionally to people like my friend, who need you as a lifeline in the dark.

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The opinion expressed in this column is that of the writer and does not necessarily reflect the opinion of the Editorial Board, the Bulletin, or the Allegheny County Medical Society.
Diagnosis: Exhaustion.

Another double shift. Deep breath, exhale. It’s time you were cared for. Prescription: The Hefren-Tillotson MASTERPLAN, a fluid formula for your life. With an in-depth discussion of your goals, MASTERPLAN develops a coordinated plan for all of your investment and financial planning needs, managed by Hefren-Tillotson. One less worry and more peace of mind.
Allegheny County was well represented at the 2016 National Advocacy Conference (NAC) in Washington, D.C. The conference, held Feb. 22-24, included lectures and visits to Capitol Hill to discuss issues involving physicians. Over the three days, Allegheny County physicians Bruce MacLeod, MD, FACEP, Brahma Sharma, MD, FACC, and myself met with congressmen as well as other physicians from across the United States to address opioid abuse, telehealth legislation, meaningful use and Congressman Tim Murphy’s mental health bill. The Pennsylvania Medical Society Political Action Committee (PAMPAC) Board also met to review state and federal elections, membership and new strategies for engagement in local races, dues billing and tools for peer recruitment.

The NAC February meeting highlights included lectures. Ken Adelman, UN Ambassador for the United States and director of U.S. Arms Control and Disarmament Agency kicked off the meeting with insights on the Ronald Reagan presidency. American Medical Association (AMA) leadership including Andy Gurman, MD, Pennsylvania hand surgeon and former speaker of the AMA House of Delegates, reviewed the AMA advocacy agenda and efforts. Chuck Todd of “Meet the Press” explained the presidential delegate landscape, painting a picture of Donald Trump and Hilary Clinton facing off in the fall election. Andy Slavitt, acting administrator of the Centers for Medicare and Medicaid, presented the new focus on improving quality while addressing disparities, outcomes and access to a program that cares for 140 million Americans.

Past lecturer at ACMS Harold Miller, president and CEO of the Center for Healthcare Quality and Payment Reform, and Richard Hellman, MD, addressed physician-focused payment models. These models act to provide better care while lowering payer spending and allowing for financially viable physician practices. Dr. Sharma and Mr. Miller accentuated the special issues facing Southwestern Pennsylvania.

MACRA, the Medicare Access and CHIP reauthorization Act to replace the SGR payment model, provides a 5 percent annual lump sum bonus payment to physicians participating in alternative payment models and exempts them from the new Merit Based Incentive Payment System (MIPS). Physicians attending the conference voiced their skepticism at the feasibility of meeting the new government standards.

The Nathan Davis Dinner was hosted by Joe Scarborough, and awardee Congresswoman Nancy Pelosi addressed the conference along with numerous physician awardees. David Certner of AARP; Steve Miller, MD, CMO of Express Scripts; and Lori Reilly, vice president of PhRMA, all discussed the rising cost and projected growth in spending on pharmaceuticals and the impact this has on patient access and adherence to medically necessary prescription drugs. Michael Botticelli, director of the White House Office of National Drug Control Policy, presented the Obama administration’s drug policy efforts. According to the Centers for Disease Control and Prevention (CDC), there were more than 160,000 overdose deaths due to opioids or heroin in the past decade, surpassing the total number of deaths during the first decade of the AIDS epidemic.

Locally, Sen. Pat Toomey has held a town hall meeting in Southwestern Pennsylvania to collect personal stories and develop his legislation that is gaining bipartisan support. Pennsylvania does have a law enforcement narcotic database, but Pennsylvania is one of the few states that does not have an opiate database that may be reviewed by physicians.

The National All Schedules Prescription Electronic Reporting Reauthorization Act (NASPER) (S 480/HR 1725) has been passed by the House. The reauthorization of NASPER and full appropriations are necessary to ensure that physicians across the country have patient-specific information through the prescription drug monitoring programs (PDMPs) at the point of care and information sharing between states. Currently, Ohio and West Virginia have PDMPs. Opioid use disorder is a chronic disease and requires care coordination and ongoing management. Coverage limits and inadequate payment rates make it difficult to provide needed treatment.
services to patients.

The drug addiction treatment act of 2000 provided for an office-based option for opiate treatment that uses buprenorphine. However, limits remain on the number of patients a physician may treat using this drug. Lifting the current patient cap is accomplished in the Recovery Enhancement for Addiction Recovery Act (HR 2536/S 1455). With the increasing use of naloxone, there will be a need for broad Good Samaritan protections that protect first responders from liability.

Finally, value-based purchasing (VBP) is derived from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), a national standardization publically reported survey of the patient perspectives of hospital-based care during an overnight stay. Since 2007, this data is collected from hospitals in order to receive full annual payment. The Affordable Care Act (ACA) included HCAHPS performance in the value-based incentive program in the hospital beginning with October 2012 discharges. Patients’ descriptions of their pain control are evaluated in their survey. The Hastings Center Report has shown that these surveys may have repercussions that impede rather than enhance the quality of care. HR 4499, the Promoting Responsible Opioid Prescribing Act of 2016, would delink pain-related measures from hospital reimbursement under the VBP program.

The Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act (S 2484/HR 4442) would advance the practice of telemedicine. Physicians strongly affirm that licensure should be required in the state a physician practices in order to comply with state regulations. The AMA currently opposes legislation that would create a federal physician license while recognizing the time and money that is required to get multiple licenses in separate states. Provisions of the current law predate the Internet and limit telemedicine to certain clinical sites and rural areas.

Meaningful Use improvements that were addressed included EMR, technology limitation, relevance to all specialties, cost and penalties. Congress enacted the HITECH Act with the best of intentions after 17 SGR patches. In 2001, 18 percent of physicians had EMR; now, 80 percent have EMR. In January, Mr. Slavitt of CMS stated, “The Meaningful Use program as it existed will now be effectively over and replaced with something better.” He also supported the transition to new payment policies under the MACRA (SGR repeal) of 2015.

Among the steps outlined by CMS are: moving the focus away from the use of specific technology and toward a focus on improved patient outcomes; ensuring that health technology is developed for individual practice needs, not the needs of the government; and concentrating on interoperability. Pilot programs could target specialties that have not been able to participate in Meaningful Use programs due to lack

Continued on Page 184
of relevant measures (i.e., radiology, anesthesiology and plastic surgery).

The PAMPAC Board met to review the state and federal legislative update. The guest speaker was Drew Kent of Congressman Charlie Dent’s office; the current marijuana bill (SB3) was discussed along with the increasing need for naloxone. Mr. Kent also discussed the new regulations that are unfolding with implementation of the ACA. U.S. House Speaker Paul Ryan has created six workgroups acknowledging that it is difficult to implement change in an election year for fear of unpopular votes.

On the state level, of the 500 bills that were introduced, 350 involved physicians and currently there are no physicians in the state legislature. There is currently legislation involving the time-consuming nature of preauthorization authored by Congresswoman Marguerite Quinn. The Governor Chief of Policy John Hanger has resigned, highlighting the gridlock that has consumed Harrisburg. Many asked, “What can a single doctor do?”

Doctors may be involved on many levels. Answering short medical society surveys gives the Pennsylvania Medical Society (PAMED) and Allegheny County Medical Society (ACMS) tangible numbers that may be used to illustrate our perspective to legislators. Marty Raniowski, previously of the Pennsylvania Health Department, has joined PAMED to spearhead policy and program implementations. He has visited ACMS and is interested in your stories. Legislators want to know what inhibits doctors from taking care of their constituents and potential voters. Healthy voters are happy voters. Real stories matter to legislators. Patients who are unable to see a doctor or cannot afford to get their medications or have to wait months for authorization are unhappy voters. It is up to us to be the communicators and continue the conversation with our state and federal legislatures to do what is best for our patients in Southwestern Pennsylvania.

The PAMPAC Board discussed having mentors for local legislator visits, having small fundraisers, or even discussing politics with our patients. In the past, discussing a patient’s bill was considered unsavory; now it is a necessity. Many patients are not seeking care due to cost and look to their physicians for advice. If doctors cannot find a way to work with the legislature, which controls the purse strings and regulations concerning medicine, then the legislature will get information from another source. This conversation may be a simple phone call, email, or visit to your congressman’s office.

If you need help or would like company, the PAMPAC Board can help to facilitate these visits. We are stronger together and we can get things done. We are more similar than different and we all want the same thing: healthy patients and a restorative home life. As PAMED and ACMS members, please consider supporting PAMPAC. Please feel free to contact me for more information.

Dr. Paré is a plastic and reconstructive surgeon and associate editor of the ACMS Bulletin. She can be reached at apare@acms.org.

The opinion expressed in this column is that of the writer and does not necessarily reflect the opinion of the Editorial Board, the Bulletin, or the Allegheny County Medical Society.

Dr. Paré is pictured with Congressman Tim Murphy at the 2016 National Advocacy Conference.
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Root causes: Doing what is necessary

It is no use saying ‘We are doing our best.’ You have got to succeed in doing what is necessary.

-Winston Churchill

As a fledgling pediatrician, I called a mother wondering why, after learning of the need months earlier, she had yet to schedule an appointment with the surgery team for her toddler’s inguinal hernia repair. On the first ring, she picked up, apologizing to me as the police were currently at her home. Her partner had just threatened her with a gun. As my years progressed, I have been able to see more and more clearly what affects families’ health: a lack of paid electric bills causing refrigerated prophylactic UTI antibiotics to go bad; chipping exterior lead-based paint blowing poison into my young patient’s back yard; literacy issues affecting dosing of a life-preserving cardiac medication. In the era where the pressure to be “productive” is focused on the number of patients we can see in a day, and how many EMR boxes we can click correctly for reimbursement and other requirements, it is no wonder that we often overlook the social determinants of health that drive the life trajectories for all of us.

We would never gloss over a tremendously elevated blood pressure, or someone vomiting on the floor of our exam room, but how often have we seen pleading eyes with deep needs, looking to us for aid, while we feel uneasy, not knowing how to truly help? I wouldn’t enjoy telling a person they have pneumonia if I didn’t know how to respond to it; is this one reason why we shy away from addressing these underlying stressors?

Knowing where to steer folks to address these other forces driving their health, and in many ways their entire life trajectories, can be extremely powerful. The joy of improving a child’s asthma by providing housing resources, connecting a lost young person with Job Corps enrollment, or leading a parent to the right match for psychiatric counseling by getting to know area counselors and psychiatrists not only feels productive, it is productive. I have found it to improve measurable factors, like emergency room utilization.

We live in a remarkable county that provides a wealth of resources to support families, if we can only connect them to these agencies. While residency taught me how to manage diabetic ketoacidosis and how to intubate a premature newborn, I had no idea that the Allegheny County Health Department has well-matched resources for families concerned about housing safety. Agencies like Every Child, Inc., can aid in coordination efforts to get medically complex children in-home therapeutic services and needed equipment. Sarah Heinz House has a magnitude of lower-priced family engagement and sports activities. Many local communities – yes, even those in better-funded school districts – have agencies to aid with in-home violence, food insecurity, transportation challenges and employment needs, if we look up from our EMR screen and into the neighborhoods where our offices sit. I have found some amazing, highly committed and skilled folks just waiting for our calls, and thrilled to speak to physicians about how they can be of best support.

Care for patients in the post-vaccine and post-antibiotic era would be barely recognizable to William Carlos Williams or Albert Schweitzer. Public sanitation, antibiotics and immunizations have vastly changed the landscape of disease evident to modern doctors. In order to support our patients to be as healthy as possible, we must recognize that the factors today driving health outcomes are those right in front of us, around us and within us. Albuterol, Concerta and Metformin are not the ideal medicinal treatments for cockroach-infested housing, domestic violence, or poor nutrition. To change the outcomes, we must change the prescription.

Dr. Nevin is a practicing pediatrician at the Hilltop Community Health Center, a federally-qualified health center in Pittsburgh. She is a grateful student to her patients and their families, who have taught her the necessity to respond to social determinants of health. She can be reached at agnevinnmd@gmail.com.

The opinion expressed in this column is that of the writer and does not necessarily reflect the opinion of the Editorial Board, the Bulletin, or the Allegheny County Medical Society.
In memoriam: Peter J. Jannetta, MD
1932-2016

Jack Wilberger, MD

Dr. Peter Jannetta, a world-renowned neurosurgeon who spent more than 50 years of his career in Pittsburgh, died recently at the age of 84.

PJ, as he preferred to be called by his colleagues and patients, made a seminal discovery in 1966 regarding the treatment of a disabling face pain known as trigeminal neuralgia, for which there was little if anything that could be done at that time – leading a number of patients to suicide.

He had concluded that the pain was being caused by a normal blood vessel continually irritating the nerve, giving sensation to the face. By moving the blood vessel away surgically – which came to be known as microvascular decompression – the pain might be relieved.

Despite considerable neurosurgical opposition to this concept, he was right.

He often said it takes 10 years for a new concept to be considered and another 10 years before it is widely accepted.

By the early 1980s, microvascular decompression had been accepted as the gold standard treatment for Trigeminal Neuralgia.

He extended his concept to other cranial nerve disorders such as hemifacial spasm and glossopharyngeal neuralgia.

Through the years, he helped multiple thousands of patients.

When he came to the University of Pittsburgh in the 1970s, he was the youngest chairman of neurosurgery in the United States. He built an impressive program, which trained hundreds of neurosurgeons – as well as innumerable visitors from outside the United States – to learn his procedure. It is said that he was responsible for training the largest number of neurosurgeons who went on to become chairmen of other neurological programs.

When his tenure ended at the University of Pittsburgh, PJ had no intention of ending his career. He moved to Allegheny General Hospital (AGH) in 2000 to continue his clinical and scientific work in the Jannetta Cranial Nerve Disorder Center at AGH.

And he continued to help so many patients through these years.

His profligate publications and research activities were less important to him than his patients.

PJ had the most amazing rapport with his patients. He would sit next to them, put his arm around them and tell them he could help – and the majority of the time he did.

While he retired from surgery several years ago, he continued to participate in resident education. Less than two weeks before his untimely death, he was still lecturing.

PJ was anything but unidimensional. He was an accomplished banjo player, and patron of the arts who donated multiple important pieces to the Westmoreland Museum of Art in Greensburg, Pa.

He is survived by his loving wife, Diana, six children, two stepchildren, eight grandchildren and two step-grandchildren.

His spirit will never be forgotten by his family, his patients and those he trained.

A public memorial service will be held at 2 p.m. June 11 at Calvary Episcopal Church, 315 Shady Ave., Pittsburgh.

Dr. Wilberger is professor of Neurosurgery at Drexel University College of Medicine and DIO and chairman, Graduate Medical Education Committee, and vice president, Graduate Medical Education, at Allegheny Health Network. He can be reached at jwilberg@wpahs.org.
ACMS member receives award

Bruce Block, MD, has been awarded the 2016 “Power to Change Our World” Award by the Family Medicine Education Consortium, Inc. (FMEC). Dr. Block specializes in family medicine and is the chief medical and informatics officer for the Pittsburgh Regional Health Initiative and the Jewish Healthcare Foundation and clinical assistant professor of the Department of Family Medicine at the University of Pittsburgh School of Medicine.

“Bruce Block’s influence on medical student education, family medicine resident training, direct patient care, quality initiatives, and medical informatics development, along with his prodigious and committed long-term service to many communities in Pittsburgh make him, in our estimation, a very humble but undoubtedly well-deserving and shining example of a family physician who is truly changing the world.” – Statement from nominators

Dr. Block joins an esteemed group of previous award winners, including Dr. Jeff Brenner of the Camden Coalition of Healthcare Providers.

FMEC is an incubator, convener and catalyst that connects those interested in improving the health of the community by strengthening family medicine/primary care services and medical education. Their primary area of focus is the northeast region of the United States.
2017 Board and Delegate Nominations

A Candidate for the ACMS Board of Directors:
• Represents physicians on issues impacting the practice of medicine and makes policy decisions for the medical society.
• Meets four times per year, special meetings as needed.

[Please print name] I am interested in the Board of Directors (Phone)

A Candidate for the ACMS Delegation to the PAMED:
• Represents physicians of Allegheny County in creating statewide policy on issues impacting physicians, patients and the practice of medicine.
• Meets as necessary prior to attending House of Delegates in October in Hershey, PA.

(Please print name) I am interested in the ACMS Delegation (Phone)

I would like to recommend the following individual(s) [Please print]

______________________________________________________________________________________ for ___ Board ___ Delegate
______________________________________________________________________________________ for ___ Board ___ Delegate

Please FAX completed form to (412) 321-5323 by Monday, June 13.

Thank you for your membership in the Allegheny County Medical Society

The ACMS Membership Committee appreciates your support. Your membership strengthens the society and helps protect our patients.

Please make your medical society stronger by encouraging your colleagues to become members of the ACMS. For information, call the membership department at (412) 321-5030, ext. 110, or email membership@acms.org.
Norman Bruce Tannehill, MD, 98, of Moon Township, died Saturday, April 9, 2016.

Dr. Tannehill graduated in medicine from the University of Pittsburgh; completed an internship at Allegheny General Hospital; and served his residency in radiology at the VA Hospital in Oakland.

Prior to his residency, he enlisted in the U.S. Army Medical Corps, serving in Europe in World War II and achieving the rank of major.

Dr. Tannehill’s medical practice included privileges at multiple Pittsburgh hospitals and a private practice in radiology oncology, followed by a career at Ohio Valley General Hospital, where he served as chief of radiology, director of the School of Radiology, and chief of the medical staff. He introduced scans, MRIs and CTs, among other procedures, to OVGH.

His wife, Maxine Hart Tannehill, is deceased. Also deceased are two sons, Fred (Virginia) Tannehill and Dr. Norman B. Tannehill Jr.; and siblings Myra Andrews, Richard Tannehill and Alice O’Connor.

Surviving are daughter-in-law Dr. Darcy B. Tannehill; grandchildren Leigh Gables, John Bruce (April) Tannehill, Courtney (Dr. Adam) Sullivan, Andrea Tannehill and Bruce Tannehill; great-grandchildren Robyn Gables, Evan Tannehill, Jackson Tannehill, Alaina Sullivan and Annie Tannehill; and several nieces and cousins.

Services were held April 13, 2016, at Copeland Funeral Home, Moon Township.

Peter J. Jannetta, MD, 84, of Oakland and Ligonier, died Monday, April 11, 2016.

Dr. Jannetta graduated in medicine from the University of Pennsylvania; completed his internship at the University of Pennsylvania Hospital, where he served a residency in general surgery; and also served a residency in neurosurgery at the UCLA Center for Health Sciences.

During his residency at UCLA, Dr. Jannetta developed a procedure known as microvascular decompression to eliminate facial spasms and the facial pain caused by trigeminal neuralgia. This development lead to his being known as one of the greatest neurosurgeons of his time.

He was a neurosurgeon at the University of Pittsburgh before joining Allegheny General Hospital to establish the Jannetta Cranial Nerve Center. He still was publishing research papers and teaching in AGH’s neuroscience residency at the time of his death.

Surviving are his wife, Diana Jannetta; his first wife, Ann Jannetta; four daughters, Susan Jannetta, Joanne Lenert, Carol Jannetta and Elizabeth Jannetta; two sons, Peter T. Jannetta and Michael Jannetta; a stepson, Robert Davant III; a stepdaughter, Hilary Rose; eight grandchildren; and two step-grandchildren.

Funeral services were private.

Narasimman Srinivasagam (Vasagam), MD, 80, died Tuesday, April 12, 2016.

Dr. Srinivasagam graduated in medicine from Madras University, India; completed his internship at Sewickley Valley Hospital; and served residencies at Allegheny General Hospital and St. Francis Hospital.

He immigrated from India to Pittsburgh in 1965, where he was a respected physician for 47 years.

Surviving are his wife, Nancy; children Kamala (Kate) Vasagam, Nalini (David Turner) Vasagam, Rachel (Sean) McDonough and Shekar (Heather) Srinivasagam; grandchildren Liam, Breanna and Dylan McDonough, Madeline and Jacqueline Perkins and Lucas and Lily Vasagam; and two nieces in India, Revathy and Dhanalakshmi.

Services were held April 17, 2016, in Tampa, Fla.
Welcoming
Nicole F. Vélez, MD
Dermatologic Surgery/Mohs Surgery

Dr. Vélez is a board-certified dermatologist and fellowship-trained Mohs surgeon. She specializes in procedural dermatology and particularly in the management and treatment of skin cancer and facial reconstruction. She performs Mohs micrographic surgery, a specialized procedure that has the highest cure rate for skin cancer, as well as excisional surgery of benign and malignant tumors, and nail surgery. She also offers a variety of cosmetic dermatology services.

She graduated cum laude and Alpha Omega Alpha from the University of Pittsburgh School of Medicine. She completed a combined internal medicine and dermatology residency at Harvard Medical School in Boston, Mass.; followed by a fellowship in Mohs micrographic surgery, nail surgery and cosmetic dermatology in East Greenwich, Rhode Island. She is board-certified by the American Board of Dermatology and the American Board of Internal Medicine.

Dr. Vélez has published over 20 peer-reviewed journal articles and lectured both nationally and internationally on skin cancer. She is a fellow of the American Academy of Dermatology and a member of the American Society of Dermatologic Surgeons, the American College of Mohs Surgeons, and the Pennsylvania Academy of Dermatology. She has medical staff privileges at Allegheny General Hospital.

As always, new patients are welcome. Most major insurances are accepted.
TAPI Governing Body Meeting and Medical Symposium held

The Tristate Association of Physicians of Indian Origin (TAPI) held a Governing Body Meeting and Medical Symposium April 17 at Airport Hyatt, Pittsburgh.

Educational programs included:
• Suad Ismail, MD: Current trends in lipid lowering therapy Non-statin agents (Who, why and when to consider PCSK9 inhibitors)
• Sunder Rao, MD: State of the Art on Novel Anticoagulant (Dabigatran and Reversal agent)
• Ravi Ramani, MD: Newer therapies for systolic congestive heart failure (Heart failure with reduced EF)

Lawrence John, MD, ACMS president, was the keynote speaker and provided an update on current practice issues.

For more information on TAPI, visit www.tapi.us.

Science & Engineering Fair held at Heinz Field

The 77th Annual Covestro Pittsburgh Regional Science and Engineering Fair was held April 1 at Heinz Field. More than 1,200 of the region’s youth participated, representing more than 100 schools from across Western Pennsylvania.

Allegheny County Medical Society Foundation participates as a corporate sponsor and provides two student awards. Additionally, ACMS Foundation members Maryann Miknevich, MD, and Ellen Mustovic, MD, participated as sponsor judges, as well as category judges for the fair.

Continued on Page 194
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2016 Award Winners

- **Aaryan Jadhar** (Peters Township High School, Grade 11); Project: “The Use of Rapid Prototyping in Catheter Ablation Procedures”
- **Ananya (Anya) Satyawadi** (Shadyside Academy, Grade 11); Project: “Effects of Angiotensin and Cell Area on Cell Death in Heart Cells;” Ms. Satyawadi will move on to represent Covestro PRSEF at the Intel International Science & Engineering Fair May 8-13 in Phoenix, Ariz.

**Clinical Update in Geriatric Medicine conference held**

More than 350 geriatrics professionals from all disciplines, including physicians, nurses, pharmacists, physician assistants, social workers, long-term care and managed care providers, and health care administrators participated in the 24th Annual Clinical Update in Geriatric Medicine conference held at the Pittsburgh Marriott City Center Hotel April 7-9.

Previously awarded the American Geriatrics Society Achievement Award for Excellence in a CME program, this conference continues to be a well-respected resource to educate healthcare professionals involved in the direct care of older persons by providing evidence-based solutions for common medical problems that afflict older adults on a daily basis and for which rapidly evolving research (much done here in Pittsburgh) is revealing new approaches that are feasible for the real world.

Under the leadership of course directors Drs. Shuja Hassan, Judith S. Black and Neil M. Resnick, the course is a premier educational event in the region, while attracting prominent international and national lecturers and nationally renowned local faculty. Daniel Blazer, MD, PhD, Sharon Inouye, MD, MPH, Lewis Lipsitz, MD, Barbara J. Messinger-Rapport, MD, PhD, FACP, CMD, and Robert Palmer, MD, MPH, comprised this year’s exceptional guest faculty.

Nearly 40 state-of-the-art sessions taught by highly regarded clinician-educators and researchers were offered during the three-day event. Each lecture, symposium and breakout session offered participants evidence-based “pearls for practice” designed to be immediately incorporated into the realities of daily practice.

The conference is jointly sponsored by the Pennsylvania Geriatrics Society – Western Division; UPMC/University of Pittsburgh Aging Institute; and University of Pittsburgh School of Nursing, in partnership with the University of Pittsburgh School of Medicine Center for Continuing Education in the Health Sciences.

**14th annual HELP conference**

The 14th annual National Hospital Elder Life Program (HELP) conference was held in conjunction with the Clinical Update conference on April 7-8. This two-day international conference educated HELP teams with strategies for delirium prevention, and insights to learn to use HELP as a way to improve hospital-wide care of the elderly, and creating a climate of change.

Expert clinicians and seasoned members of the HELP sites shared evidence-based information and their clinical insights on selected topics regarding the influence of HELP, delirium updates and the larger policy implications of care for the elderly. The conference attracted a record number of registrants (81) representing numerous states, including international participants from Canada, Germany and Japan.

Serving as course directors were Fred Rubin, MD, chair, Department of Medicine, UPMC Shadyside, professor of Medicine, University of Pittsburgh School of Medicine, and president of the Pennsylvania Geriatrics Society – Western Division; and Sharon Inouye, MD, MPH, professor of Medicine, Beth Israel Deaconess Medical Center, Harvard Medical School, Milton and Shirley F. Levy Family Chair, director, Aging Brain Center, Institute for Aging Research, Hebrew SeniorLife.

This innovative model program, designed by Dr. Inouye, improves the
hospital experience for older patients by helping them maintain their cognitive and functional abilities; maximizing independence at discharge; assisting with the transition to the home; and preventing unplanned readmission.

Through HELP, the hospital becomes a place where older patients can feel secure as they participate in their course of treatment and maintain some control over their own recuperation. Hospitals around the world have implemented the program, and HELP has received extensive coverage in medical journals and mainstream media.

For more information on HELP and delirium, or to learn how to become a HELP site, visit www.hospitalelderlife-program.org.

PAGS-WD announces student, teacher award recipients

The Pennsylvania Geriatrics Society – Western Division is proud to announce the 2016 recipient of the David C. Martin Award: Ms. Rebecca Abay, a medical student attending the University of Pittsburgh School of Medicine.

Ms. Abay received an honorarium to defray the expenses of attending the 2016 Annual Scientific Meeting of the American Geriatrics Society conference, where her abstract, Bone Microarchitecture is Preserved in Men With Prostate Cancer on Androgen Deprivation Therapy, was selected for poster presentation.

The award was named after David C. Martin, MD, who established the first geriatrics fellowship in Pittsburgh, Pa. The ultimate goal of this prestigious award is to encourage and prepare future physicians in the field of geriatric medicine.

Since its inception, the Society is proud to have awarded more than $79,000 to area medical students interested in the field of geriatric medicine.

The society also acknowledged geriatrics teachers with special recognition for their dedication and commitment to geriatric education. Daniel DiCola, MD, and Betty Robison, MSN, RN-BC, were recognized as the 2016 recipients of the Geriatrics Teacher of the Year Award (Physician and Healthcare Professional, respectively) prior to the dinner symposium at the 24th Annual Clinical Update in Geriatric medicine April 7.

Rollin Wright, MD, MS, MPH, awards chair, instrumental in the award’s inception, provided remarks on the newly established award. She engaged the audience of more than 80 attendees by highlighting the achievements and significant contributions Dr. DiCola and Ms. Robison have made to the education and training of learners.
Allegheny County Medical Society members:

The new world of Health Care ushered in by the Patient Protection and Affordable Care Act (ACA) has created uncertainty and confusion for most people. There are new regulations and requirements. Individual and employer mandates. Penalties for not purchasing coverage. On Exchange and Off Exchange access. As an Allegheny County Medical Society member, you have help.

Talk to USI Affinity, the ACMS’s endorsed insurance broker and partner. Our benefits specialists are experts in Health Care Reform. We can help you choose a health plan that provides the best coverage and value while ensuring you will be in compliance with complex new IRS and Department of Labor regulations. We’ll also provide you the kind of world class service and support you need to make sure you get the most out of your health care benefits after you buy.

You can also check out the NEW Allegheny County Medical Society Insurance Exchange, a convenient and secure online portal where you can find competitively priced insurance coverage for all your needs, including a wide variety of medical and dental plans.

To learn more, contact USI Affinity today!
Call 800.327.1550, or visit the ACMS Insurance Exchange at www.usiaffinityex.com/acms
in geriatrics and presented each with a plaque.

Dr. DiCola is director of Geriatrics Education, Latrobe Area Hospital Family Medicine Residency Program; associate professor of Family Medicine, Jefferson Medical College/Sidney Kimmel Medical College; and medical director, IHS Mountain View Nursing Home.

In his remarks, Dr. DiCola expressed gratitude to the society for its ongoing commitment to providing quality education to health care professionals through continued involvement and planning of the Clinical Update conference.

Ms. Robison is gerontology educator, Aging Institute of UPMC Senior Services, and adjunct faculty, Chatham University.

Ms. Robison also expressed sincere thanks to the society for recognizing the role geriatric education teachers play in training health care professionals.

Nominations for the 2017 Geriatrics Teacher of the Year award will be accepted in September 2016. Award eligibility, criteria and complete nomination process information will be available on the society website.

Controversies in Geriatric Medicine program set

The Pennsylvania Geriatrics Society – Western Division is hosting the 2nd Annual Controversies in Geriatric Medicine program June 16 at the Herberman Conference Center, Pittsburgh, beginning at 6 p.m. with registration and networking, followed by dinner and program at 6:45 p.m. The program serves to enhance the suite of existing educational programs offered by the Society. Internists, family practitioners, geriatricians, nurse practitioners, physician assistants, pharmacists and other health care professionals who provide care to older adults will find the program to be a beneficial resource. The program is sponsored by Optum, the University Center for Social and Urban Research and the University of Pittsburgh School of Medicine, Center for Continuing Education in the Health Sciences.

“The Difficult Daughter” presents the case of an 84-year-old woman with severe dementia who is bedbound and nourished via gastrostomy and lives with her daughter, but is frequently hospitalized. Her complex management is made more challenging by the need to negotiate every step with her daughter. A panel of the physicians who treat her will discuss management from their individual perspectives and invite audience participation. Panel presenters will address management areas to include: dealing with challenging family members and identifying strategies that health care professionals can use to manage difficulties; management of bullous pemphigoid; as well as discussion of treatment plans of pressure ulcers (based on patient characteristics and pressure ulcer stage).

Syeda Arabi, MD, geriatric medicine fellow, division of geriatric medicine, University of Pittsburgh, will present this interesting case with Fred Rubin, MD; 2016 Geriatrics Teacher of the Year (Physician) Award recipient Daniel DiCola, MD; and PAGS-WD Awards Chair Rollin Wright, MD, MS, MPH.
The Pittsburgh Urology Associates met April 20 at Eddie Merlot’s in Pittsburgh. The guest speaker was Gary M. Kirsh, MD, president of The Urology Group in Cincinnati. Dr. Kirsh presented “Provenge – For the treatment of advanced prostate cancer: Urology Perspective.” At left are PUA President Jay Herman, MD, and Dr. Kirsh. Above, from left, are PUA members Rong-Chung Lin, MD; Justin Isariyawonger, MD; Thomas Rosvanis, MD; Dr. Herman; and Stephen Jackman, MD.
The Pittsburgh Regional Science and Engineering Fair, arranged by Carnegie Science Center, a division of Carnegie Institute of Museums, Pittsburgh, was held April 1, 2016, at Heinz Field.

The program generates interest in science and technology among young students from grades six through 12 and inspires kids to pursue careers in the academic disciplines of science, technology and engineering. Winners are selected by sponsor judges from business, industry, commercial and community organizations. Sponsors are elicited and selected by Carnegie Science Center organizers.

Through annual participation as sponsor/judges, Allegheny County Medical Society Alliance (ACMSA) has been proud to support the fair for the past quarter century.

This year, ACMSA’s Mrs. Sandra DaCosta and Dr. John DaCosta served as exhibit judges in the science sector of the CSC/PRS&E Fair.

More than 1,200 students from more than 100 schools across Western Pennsylvania participated in competition for more than $1 million in cash prizes and scholarships.

ACMS ALLIANCE MEETING
WRAP-UP 2016 ■ 2017 KICK-OFF
Allegheny County Medical Society Building
713 Ridge Ave.
ample on-site parking
Tuesday, June 21, 2016
10:30 a.m.
Beverage and Light Lunch
RSVP by June 14
Alliance at (412) 321-5030

Dr. Hirsch

Pa. lawmakers legalize medical marijuana

Despite opposition from PAMED, on April 13, the Pennsylvania legislature passed Senate Bill 3 – a bill legalizing medical marijuana. Gov. Tom Wolf signed the bill into law April 17.

More information is available at https://www.pamedsoc.org/advocate/topics/medical-marijuana.
Genvoya® is a novel, four-in-one medication for the treatment of HIV. It contains an integrase inhibitor (elvitegravir), a CYP inhibitor (cobicistat) and two nucleoside reverse transcriptase inhibitors (emtricitabine and tenofovir alafenamide). Compared to its predecessor approved in 2012 (Stribild®), Genvoya contains the same components with the exception of its tenofovir formulation. Tenofovir disoproxil fumarate (TDF), the component in Stribild, has many adverse effects that lead to treatment discontinuation, including renal and bone toxicity. Tenofovir alafenamide (TAF), the component in Genvoya, is a novel tenofovir prodrug, resulting in four times greater intracellular concentrations (antiviral activity) than TDF. This allows for much lower doses of tenofovir to maintain equal efficacy, translating to 90 percent less plasma exposure and a significant reduction in side effects.

Safety

Genvoya should not be used in patients with a history of treatment failure or known resistance to any of its individual components. If it is being used to replace a current antiretroviral regimen, the patient must have been on that regimen for at least six months and have a suppressed viral load (HIV-1 RNA < 50 copies/mL).

Rare but life-threatening side effects include lactic acidosis and severe hepatomegaly with steatosis (<1 percent incidence, but increased risk in those with liver disease). Genvoya may be used during pregnancy if the potential benefit justifies the risk, as it has a Pregnancy Category B rating. Pregnant patients should be enrolled in the Antiretroviral Pregnancy Registry.

Because patients with severe hepatic and renal impairment were excluded from clinical trials, Genvoya is not recommended for use in patients with CrCl < 30 mL/min or Child-Pugh Class C.

Tolerability

The adverse effect profile of Genvoya has been shown to be significantly improved over Stribild. Specifically, renal function (change in GFR) and bone mineral density (change in DEXA score) were less affected in patients taking Genvoya compared to those taking Stribild in a phase III study.1 Another phase III study of patients switching HIV regimens demonstrated that patients on Genvoya experienced significantly fewer renal, bone and psychiatric adverse events leading to discontinuation than controls (0.9 percent vs. 2.5 percent).2

Common adverse effects of Genvoya include nausea (10 percent), diarrhea (7 percent), headache (6 percent) and fatigue (5 percent). Genvoya also can increase cholesterol, HDL, LDL and triglycerides, and may increase lipids more than Stribild.

Efficacy

Genvoya was compared to Stribild in 1,733 treatment-naïve adults. At baseline, 23 percent of patients had viral loads > 100,000 copies/mL. By week 48, 92 percent of Genvoya and 90 percent of Stribild-treated patients had viral loads < 50 copies/mL. The mean increase from baseline CD4+ cell counts was 230 cells/ mm³ in the Genvoya group and 211 cells/mm³ in the Stribild group. In summary, Genvoya was found to be non-inferior to Stribild in treatment-naïve adults.1

The efficacy and safety of switching to Genvoya from Stribild, Atripla, or Truvada + atazanavir was studied in 1,196 adults who had been on their treatment regimen for at least six months and had a viral load < 50 copies/mL. Subjects were randomized to either switch to Genvoya or stay on their baseline regimen. At week 48, 96 percent of Genvoya patients and 93 percent of other treatment patients had maintained the viral load < 50 copies/mL. The mean increase in CD4 count was 33 cells/ mm³ in the Genvoya group and 27/ mm³ in the other groups. In summary, Genvoya was found to be significantly more effective in patients switching from therapies (other than Stribild) to Genvoya.2
Price

A one-month supply (30 tablets) of Genvoya costs about $3,000, but it often is covered by local insurance companies after a prior authorization from the provider.

Simplicity

Genvoya is taken orally once daily with food. The dose is elvitegravir 150mg, cobicistat 150mg, emtricitabine 200mg and tenofovir alafenamide 10mg.

Bottom line

Genvoya is a novel four-in-one medication for HIV in both treatment-naïve and treatment-experienced patients. It differs from Stribild only in the tenofovir component (alafenamide in Genvoya and disoproxil fumarate in Stribild). In clinical trials, it has shown equal efficacy and a significant reduction in renal and bone mineral density side effects compared to Stribild.

Dr. Bondar is a PGY1 pharmacy practice resident at UPMC St. Margaret and can be reached at bondarar4@upmc.edu. Dr Campbell is a PGY2 geriatric pharmacy resident at UPMC St. Margaret and can be reached at campbellam5@upmc.edu. Heather Sakely, PharmD, BCPS, served as editor, and is the director of Geriatric Pharmacotherapy and the director of the PGY2 Geriatric Pharmacy Residency Program and can be reached at sakelyh@upmc.edu.

References


Who Do You Know?

Who you know may help the future of medicine.

Are you friends with a state legislator? Your Congressman? If so, PAMED wants to know.

As part of our grassroots action team, we seek members who know elected leaders and are willing to talk to them about issues?

Visit www.pamedsoc.org/gotnames and complete the online form to join the team today or email Larry Light at llight@pamedsoc.org.
Employed physician liability for compliance issues: 
Contractual, regulatory and governmental traps

Ol der physicians, tired of the time lost and expenses incurred attempting to keep pace with the over-proliferation of new rules, regulations and initiatives. New physicians, fresh out of residencies or fellowships, wanting to focus on the practice of medicine rather than the challenges of starting or eventually managing a business. Physicians in the middle of their careers whose practices are purchased by a hospital system. All of these physicians, as employees of larger health care organizations, are likely glad to be relieved of the burden of complying with ever-changing rules, regulations and reimbursement methodology from both private and public sectors. But are they truly relieved of this burden? Due to common provisions in physician employment contracts, the Medicare reassignment rules and the increasing tendency of governmental agencies to pursue individuals in addition to corporate wrongdoers, the answer is a resounding “no.”

Contractual liability

Physician employment contracts in Western Pennsylvania typically require the physician employee to comply with a plethora of items: licensure regulations; medical staff bylaws and corporate policies, including human resources policies; compliance programs (sometimes with financial penalties for failing to do so); federal and state laws regarding referrals, privacy and security (HIPAA) and other issues related to health care; and, perhaps most importantly, coding, billing and documentation requirements of Medicare, Medicaid and other third-party payers. Moreover, many such contracts have specific indemnification provisions requiring a physician to cover the employer’s costs, damages, attorneys' fees, etc., for claims relating to professional malpractice, sexual harassment or discrimination by the physician, failure to comply with applicable laws, rules and regulations, and third-party payer reimbursement. An indemnification clause might look something like this:

*Employee shall indemnify Employer from and against any liabilities, costs, damages or other losses caused by Employee’s performing or failing to perform any duties, including but not being limited to third-party payer refund claims for fraudulent, negligent or otherwise illegal or improper billing and including claims involving professional services.*

If a physician who signed an agreement with such a clause does not pay attention to how she is billing for services, or does not adequately document the services, she will have to pay out of pocket for amounts that are recouped by third-party payers and potentially even penalties relating to those claims: Professional liability insurance generally does not cover such conduct or contractually assumed liability. Being an employed physician in such circumstances does not absolve one of the need to understand billing and documentation requirements of third-party payers.

The Medicare reassignment rule

In order for an employer to bill for a physician’s professional services, the physician must execute a reassignment of benefits form (for Medicare, the CMS855-R). The Medicare regulations regarding the reassignment of benefits provide that both the physician and the employer are jointly and severally liable for all claims submitted pursuant to a reassignment and, further, that the employer must give the physician access to all claims submitted for the physician’s services. If the employer fails to do so, its Medicare billing privileges may be revoked. Even if the physician does not do the actual coding, he may be liable for miscoded claims resulting in overpayments.
Accordingly, it behooves physicians to both understand coding for the services they provide and to review and understand what their employers are billing for their services.

**Other government initiatives to hold individuals accountable**

For years, the various agencies investigating health care fraud – the Office of Inspector General (OIG) and the Department of Justice (DOJ) primary among them – pursued only corporations. Given limited governmental resources at the time, it made sense for them to go after the “deep pockets” of the corporations and reach monetary settlements as opposed to seeking criminal charges, which are much harder to prove, against the individuals within the corporation who were responsible for the wrongdoing. As the various programs and initiatives paid off handsomely, more resources were devoted to fighting health care fraud. With those resources and more data transparency initiatives came the agencies’ determinations to simultaneously pursue both corporate and individual wrongdoers from the beginning of the investigatory process. In July 2015, the OIG announced the creation of a new litigation team whose function was to impose civil monetary penalties on and/or exclude from the Medicare program those individuals responsible for health care fraud and abuse. This was followed several months later with a memorandum to all DOJ attorneys authored by U.S. Deputy Attorney Sally Quillian Yates, entitled “Individual Accountability for Corporate Wrongdoing” (aka the Yates Memo). The new policy set forth in the Yates Memo is based on the concept that:

*One of the most effective ways to combat corporate misconduct is by seeking accountability from the individuals who perpetrated the wrongdoing. Such accountability is important for several reasons: it deters future illegal activity, it incentivizes changes in corporate behavior, it ensures that the proper parties are held responsible for their actions, and it promotes the public’s confidence in our justice system. Yates Memo, p.1.*

The gist of the Yates Memo is that, from the beginning, all investigations must pursue both the corporate entity and the individuals responsible for the actual conduct that constituted the violation(s), and that both corporate and individual liability are to be resolved before a matter is closed. Moreover, a corporation must provide the DOJ with “all relevant facts about the individuals involved” in the fraud or other misconduct if they want to receive “cooperation credit” under the Principles of Federal Prosecution of Business Organizations. Individuals, therefore, can no longer count on being “protected” by a corporate settlement with the DOJ or OIG if they in any way participated in or were in a position to stop the misconduct.

**The take-away**

Much as the world would be a better place if physicians were left to concentrate on preserving health and healing the sick, the reality is that, employed or not, physicians must remain aware of the compliance obligations that applicable law, contracts (including employment contracts and provider agreements) and employer policies impose upon them and fulfill those obligations. If they fail to comply with these requirements, physicians may become individually liable for their actions or failure to act. To minimize this liability, physicians should carefully review their contracts with an attorney before signing, review their contracts from time to time to

Continued on Page 204
remain cognizant of their obligations, attend all mandatory compliance training sessions, confer with their employer’s compliance department for assistance when in doubt, and ask for and review billing reports from their employer. If any miscoding is detected (whether undercoding or upcoding), physicians should bring it to the attention of the proper manager(s) and, if necessary, report it to the compliance officer.

**DISCLAIMER:** This article is for informational purposes only and does not constitute legal advice. You should contact your attorney to obtain advice with respect to your specific issue or problem.

Ms. Jackson is the sole member of Beth Anne Jackson, Esq. LLC, a law firm that serves the legal needs of health care practitioners and facilities in western and central Pennsylvania. She may be reached at (724) 941-1902 or bjackson-law@verizon.net. Her website is: www.jackson-healthlaw.com. Follow her on Twitter @bajhealthlaw1.

References
1. The same conditions apply when benefits are reassigned pursuant to an independent contractor relationship.
2. 42 CFR § 424.80(d).
3. Between 1997 and the end of FY 2014, the joint OIG-DOJ Healthcare Fraud and Abuse Control Program recovered over $27.8 billion for the Medicare Trust Fund.
4. These initiatives include the Medicare Part B physician FFS payment database, the Medicare Part D prescription drug database, and the “Open Payments” database showing industry payments to physicians, all of which are open to the public on the Internet.

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**SPECIAL REPORT**

What can I do if I did not meet Meaningful Use in 2015?

**W**ere you able to submit a Medicare Meaningful Use attestation by the March 11 deadline? If not, you may be able to avoid a Medicare penalty in 2017 if you apply for a hardship exemption by July 1, 2016. Contact Quality Insights to learn what you need to do.

Quality Insights Quality Innovation Network provides tools and resources, email alerts and educational opportunities to participating practices. Our goals include:
- Improving EHR adoption rates, workflows, practice transformation, achieving meaningful use and attestation
- Increasing eligible professionals and eligible hospitals screening and delivery of preventive services for Medicare beneficiaries
- Improving care access and coordination for Medicare beneficiaries
- Reducing disparities in access and utilization of healthcare services for Medicare beneficiaries

All assistance is provided free of charge under a contract that Quality Insights has with the Centers for Medicare & Medicaid Services (CMS) through July 2019.

Learn more about how Quality Insights can get your practice back on track. Contact Lisa Sagwitz at lsagwitz@wvmi.org or (877) 725-9998, ext. 7714, or (412) 655-7356 to get started.

**About Quality Insights**

As the Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for Pennsylvania, New Jersey, Delaware, West Virginia and Louisiana, Quality Insights is committed to collaborating with providers and the community on the Centers for Medicare & Medicaid Services’ goals of better health, smarter spending and healthier people. Our data-driven quality initiatives improve patient safety, reduce harm and improve clinical care locally and across the network. To learn about Quality Insights’ health care quality improvement initiatives, visit www.qualityinsights-qin.org.
The Gateway Medical Society shares the following updates:

- **Gateway Medical Society** won the National Medical Association's Society of the Year honors for August 2015 – August 2016. This is a nationwide honor while giving tribute to the impact of the Society’s annual community symposiums (10 years) and especially for its “Journey to Medicine” Academic Mentorship Program.

- William Simmons, MD, Anita Edwards, MD, and Jan Madison, MD, were honored May 5 at the Heinz Museum in Pittsburgh as one of the 50 winners of the region’s Jefferson Award for Volunteerism, 2015-16. Drs. Simmons, Edwards and Madison also were honored with a secondary award of Top Volunteer for 2015-16 which signifies the most outstanding volunteer project in the Western Pennsylvania region.

- Dr. Simmons, president of Gateway Medical Society and visiting associate professor, University of Pittsburgh School of Medicine, was honored at the University of Pittsburgh Honors Convocation for Volunteerism secondary to his winning the Jefferson Award. He also was honored in January 2016 with an Exemplary Service Award from the Pittsburgh Community Alliance and Achieving Greatness, Inc.

- The Pittsburgh School Board has awarded Gateway Medical Society’s “Journey To Medicine” Program partner status for 2015-16. In 2015, the state of Pennsylvania awarded Gateway Medical Society’s “Journey to Medicine” program Education Investment Tax Credit (EITC) for its 2015 corporate donations. The Society is in the process of reapplying for 2016 donations.

- This is a special year for the Society’s “Journey To Medicine” Academic Mentorship Program. After almost seven years, the first class is graduating from the city's high schools. Ten out of the original 15 boys enrolled stayed with the program. All have gotten into the college of their choice. Eight have an equivalent to a full scholarship considering the Pittsburgh Promise citywide scholarships, college grants and local scholarships. The Society presently has 110 students in this Academic Mentorship pipeline program.

- Additionally, a half-hour PBS/WQED Public Cable TV special called “Journey to Medicine” was filmed in Pittsburgh and focused on the program, African American Medical Students at UPSOM and cameos of African American University of Pittsburgh Staff discussing their path to medicine and insights on the topic. This special was initially only shown in Western Pennsylvania, however, it won a journalism award for PBS and then was shown nationally several times. This special can be viewed at http://www.wqed.org/tv/portrayal/?id=8.

- Gateway Medical Society will hold its 2016 Community Symposium Saturday, June 4, which will include three different functions with a specific program and speaker for each segment: the Men’s-only segment (60-80 attendees and growing); the Women’s-only area (150-250 attendees); and the Teenage program (90-100 teenagers). Shadyside Hospital and the Hillman Cancer Center are partners in this free event.

- A Medical Provider Symposium is planned for Saturday, Sept. 10. Gateway Medical Society and Allegheny County Medical Society have partnered together for the last three years to discuss issues of disparities in medicine or the impact of the Affordable Care Act on practices in the region.

- Gateway Medical Society’s Physician of the Year and Scholarship Gala will be held Saturday, Oct. 29, at the Marriott City Center in downtown Pittsburgh. The 2016 Physicians of the Year awardees are Drs. Raymond Wynn and Gregory Patrick. Additionally, three Society members will be honored with Lifetime Achievement Awards (Drs. Edward James, Robert Thompson and Theodore Yarboro). The president of the National Medical Association, Dr. Edith Mitchell, will attend the Gala.

For more information on the Gateway Medical Society, visit http://www.gatewaymedicalsociety.org/.
For more than two decades, the Allegheny County Medical Society (ACMS) and ACMS Alliance have demonstrated an unrelenting commitment to providing scholarship funds to Community College of Allegheny County (CCAC) students enrolled in nursing and allied health programs. Since 1992, the ACMS Foundation has donated more than $176,050 to support a total of 231 scholarship recipients.

When ACMS initiated their partnership with CCAC in 1992, they awarded eight stipends in the amount of $500 and eight scholarships in the amount of $1,000. They continued awarding annual scholarships until 2012, when the ACMS Foundation contributed an additional $33,000 to establish an endowed scholarship.

The scholarship has been awarded to five students for this academic year.

• Kayla Bilak: Respiratory Therapy major
• Katherine Jenkins: Nursing major
• Svetlana Miller: Diagnostic Medical Sonographer major
• Sandra Regan: Dietetic Technician major
• Caitlin Wagner: Future nursing major

Below are excerpts from thank-you letters sent by these recipients:

"I am writing to express my sincerest gratitude to you for making the Allegheny County Medical Society Health Careers Scholarship possible. I was thrilled to learn of my selection for this award and I am honored to have been chosen for it. I can’t thank you enough for your support, as this scholarship will help me attain my goal of being a young Respiratory Therapist."

"I will take this generous grant and put it towards my books and tuition, as this will help me to focus more on my studies. I promise that I will work my hardest not only to graduate from this wonderful program, but to also bring joy and health to my future patients." – Kayla Bilak

"I am writing to thank you for your generous $500 health career scholarship. I was very excited and appreciative to learn that I was selected as the recipient of your scholarship."

"I am a returning student, and I work full time to pay for my tuition, so your award will help to ease my financial burdens and allow me to focus on the most important aspect of school, which is learning. Your generosity has inspired me, and I hope that in the future I will be able to be a part of an organization that helps students in similar situations achieve their goals. Thank you again." – Katherine Jenkins

"Please accept my tremendous gratitude for the Allegheny County Medical Society Health Careers Scholarship. It is impossible to fully express how much this award means to me. It means that I can breathe a little easier this semester, knowing that some of the financial burden of the cost of my education has been lifted off my family’s shoulders."

"It is because of you I get to feel special today. Generous people like you give me a new inspiration to continue to work hard towards my goals. I am excited to one day use the skills I am acquiring at CCAC in the Diagnostic Medical Sonography program to provide the best care to patients, and to be a part of their journey to health and wellness." – Svetlana Miller

"I would like to express my sincere gratitude to the donors of the Allegheny County Medical Health Careers Scholarship for the award of a scholarship for Fall 2015.

"I have returned to school as an adult after having my children and am thrilled to have the opportunity to work toward my degree as a Dietetic Technician at CCAC. CCAC is an invaluable resource for those of us who choose to return to school as non-traditional students, making going back to school more affordable, less intimidating and more supportive than a traditional college environment." – Sandra Regan

"I am writing to express my sincere gratitude to you for making the Allegheny County Council Endowed Scholarship possible. I was thrilled to learn of my selection for this honor and I am deeply appreciative of your support."

"The financial assistance you provided will be of great help to me in paying my educational expenses, and it will allow me to concentrate more of my time for studying. Thank you again for your generosity and support. I promise you I will work very hard and become the incredible nurse I want to be." – Caitlin Wagner
Regional Health Literacy Coalition forum: Moving Health Literacy Forward

The Regional Health Literacy Coalition’s first community learning forum of the year was held March 31. The purpose of this meeting was to review the coalition’s work from the past three years, then to consider other related collaborative health and health literacy efforts, all in the hope of helping all three efforts consider priorities for moving their work forward.

Here’s an aggregated look at how the individual attendees rated each set of priorities. Please note that much of the discussion often suggested that some of priorities “worked together” or “related to all of the other,” so interpret these results with caution:

Regional Health Literacy Coalition

1. Continue working to address the priority areas agreed to in 2013
2. Focus on delivering tools to consumers and training to providers
3. Support local collective impact efforts to improve health in SWPA
4. Advocate for projects that emphasize design and person-centered health care
5. Unite with partners from across the state to address health literacy challenges

Pennsylvania Health Literacy Coalition

1. Catalog existing health literacy programs and trainings around the state
2. Raise awareness of local and regional health literacy work
3. Support organizations in adopting health literate policies and practices
4. Provide funding for smaller projects or workgroup activities
5. Pursue efforts to create statewide policies that promote health literacy

Allegheny County Health Department

1. Set a broad vision for health and provide overall direction
2. Convene partners that have an impact on health through Live Well Allegheny
3. Measure, analyze and track progress toward community-wide health outcomes
4. Provide specific resources on evidence-based practices to organizations
5. Develop and support the implementation of policies that impact health

Summary

The meeting began with a reminder of the RHLC priority areas and how they were decided upon. A few examples of goals accomplished in that domain were highlighted. One example under “Try Projects & Assess Outcomes” related to the co-designing health tools course that was offered through a partnership with many of our members and the School of Design at Carnegie Mellon University.

To better illustrate that example, we took an in-depth look at LifeKey. A closer look is available by visiting a student team member’s personal website: http://www.yooyoungko.com/lifekey/. Our hope is to continue using person-centered approaches to develop projects and ways of assessing their success. LifeKey was one of five concepts that was developed over the semester-long course. A pilot project is currently being developed with Children’s Hospital of Pittsburgh of UPMC to co-design materials that support teens with disabilities in transitioning from pediatric to adult health care environments.

Next, attendees heard about the Allegheny County Health Department’s “A Plan for a Healthier Allegheny” and the many efforts to address the key concerns discovered in the report in a coordinated way. RHLC will review the report more closely in order to find tactical and reportable ways for our members to integrate their health literacy efforts to advancing the plan and improving health. For a specific example of an initiative led by ACHD, an overview of the Live Well Allegheny Campaign was provided. RHLC recently has become a proud partner of the campaign and would encourage all of our individual members working in Allegheny County to do the same, if they have not already.

The final presentation came from the Health Care Improvement Foundation. They profiled their success to date with SEPA-READS, a health literacy program offered throughout Southeastern Pennsylvania since 2010. They also discussed how that program and a

Continued on Page 208
working relationship with the Pennsylvania Department of Health led to additional funding to support the creation of a state-wide health literacy coalition. It was noted that all RHLC members are encouraged to attend the Second Annual Pennsylvania Health Literacy Coalition Meeting May 17.

What we learned through breakout conversations

- In all three breakout groups, the compiled individual responses closely reflect the priority lists generated from group conversations. This was a pleasant surprise.
- Responses across all groups and individuals tended to be pragmatic in nature with short-term or clearly defined priorities raising to the top of most lists.
- There were a few “surprises” for each group:
  - For RHLC, it was that the consensus seemed to be “to stay the course”
  - For PA-HLC, it was that idea of providing small funding opportunities finished in the bottom two of most lists
  - For ACHD, it was the limited awareness around county health rankings, so this discussion was helpful in highlighting this key set of metrics

Find information about events, training options and more at ahealthyunderstanding.org.

Mr. Progar is project manager for the Regional Health Literacy Coalition. He can be reached at kevin@ahealthyunderstanding.org.

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PRHI contributes to book on improving health care

Pittsburgh Regional Health Initiative (PRHI) president and CEO Karen Wolk Feinstein, PhD, joined with 35 internationally recognized health care experts to publish a book on using health care collaboratives to improve the health care system.

Dr. Feinstein and Nancy Zionts, the Jewish Healthcare Foundation’s chief operating and program officer, contributed a chapter on engaging patients and families to improve health outcomes. PRHI Chief Medical and Informatics Officer Bruce Block, MD, and Dr. Feinstein contributed another chapter on translating knowledge into action on the front lines of health care. PRHI Consultant Susan Elster, PhD, contributed a case study on PRHI’s Champions programs, which provide clinical leaders from various disciplines with skills to stimulate organizational success.

The book, “All In: Using Health-care Collaboratives to Save Lives and Improve Care,” is now available on Amazon.

There are currently two openings on the Bulletin Editorial Board for ASSOCIATE EDITOR.

For more information, contact Bulletin Managing Editor Meagan Welling at mwelling@acms.org.
2016 ACMS Bulletin

Photo Contest

The 2016 Photo Contest will be held completely online. Please note instructions for participation below:

1. Email your VERTICAL jpg photos with a resolution of 300 dpi or higher to bulletin-contest@acms.org. Photos should be 8”W x 10”H but can be resized if the resolution is high enough.


3. Include the name of the photo (please keep file names short) as well as your name, specialty, address and phone number in the email.

4. You will receive verification that your photo has been received and is eligible to be entered in the contest.
   a) Horizontal photos will not be considered.
   b) Photos with low resolution will not be considered.
   c) Panoramic shots or photos featuring specifically identifiable individuals/relatives will not be considered.

5. The deadline for submission is Friday, August 26, 2016. Voting will open after this date.

6. Participants are permitted to submit three photos but are limited to two winning entries.


8. Winners will be announced on the website, in the Bulletin and via email. The 1st-place winner’s photo will appear on the January 2016 cover; the remaining winning photos will appear on Bulletin covers throughout the year.

9. Please continue to check the ACMS website and future issues of the Bulletin for further updates and reminders.

10. If you have any questions, please call Bulletin Managing Editor Meagan Welling at (412) 321-5030, ext. 105, or email mwelling@acms.org.
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